SOURCE: 62 FR 16958, Apr. 8, 1997, unless otherwise noted.

Subpart A—General Provisions

§ 146.101 Basis and scope.

(a) *Statutory basis.* This part implements sections 2701 through 2723 of the PHS Act. Its purpose is to improve access to group health insurance coverage, to guarantee the renewability of all coverage in the group market, and to provide certain protections for mothers and newborns with respect to coverage for hospital stays in connection with childbirth. Sections 2791 and 2792 of the PHS Act define terms used in the regulations in this subchapter and provide the basis for issuing these regulations, respectively.

(b) *Scope.* A group health plan or health insurance issuer offering group health insurance coverage may provide greater rights to participants and beneficiaries than those set forth in this part.

(1) *Subpart B.* Subpart B of this part sets forth minimum requirements for group health plans and health insurance issuers offering group health insurance coverage concerning:

(i) Limitations on a preexisting condition exclusion period.

(ii) Certificates and disclosure of previous coverage.

(iii) Methods of counting creditable coverage.

(iv) Special enrollment periods.

(v) Use of an affiliation period by an HMO as an alternative to a preexisting condition exclusion.

(2) *Subpart C.* Subpart C of this part sets forth the requirements that apply to plans and issuers with respect to coverage for hospital stays in connection with childbirth. It also sets forth the regulations governing parity between medical/surgical benefits and mental health benefits in group health plans and health insurance coverage offered by issuers in connection with a group health plan.

(3) *Subpart D.* Subpart D of this part sets forth exceptions to the requirements of Subpart B for certain plans and certain types of benefits.

(4) *Subpart E.* Subpart E of this part implements sections 2711 through 2713 of the PHS Act, which set forth requirements that apply only to health insurance issuers offering health insurance coverage in connection with a group health plan.

(5) *Subpart F.* Subpart F of this part addresses the treatment of non-Federal governmental plans, and sets forth enforcement procedures.

[62 FR 16958, Apr. 8, 1997, as amended at 63 FR 57559, Oct. 27, 1998]

Subpart B—Requirements Relating to Access and Renewability of Coverage, and Limitations on Preexisting Condition Exclusion Periods

§ 146.111 Limitations on preexisting condition exclusion periods.

(a) *Preexisting condition exclusion*—(1) *General.* Subject to paragraph (b) of this section, a group health plan, and a health insurance issuer offering group health insurance coverage, may impose, with respect to a participant or beneficiary, a preexisting condition exclusion only if the requirements of this paragraph (a) are satisfied.

(1)(i) *6-month look-back rule.* A preexisting condition exclusion must relate to a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the enrollment date.

(A) For purposes of this paragraph (a)(1)(i), medical advice, diagnosis, care, or treatment is taken into account only if it is recommended by, or received from, an individual licensed or similarly authorized to provide such services under State law and operating within the scope of practice authorized by State law.

(B) For purposes of this paragraph (a)(1)(i), the 6-month period ending on the enrollment date begins on the 6-month anniversary date preceding the enrollment date. For example, for an enrollment date of August 1, 1998, the 6-month period preceding the enrollment date is the period commencing on February 1, 1998 and continuing through July 31, 1998. As another example, for an enrollment date of August 30, 1998, the 6-month period preceding